## REQUEST FOR ADDITION/APPLICATION FOR REINSTATEMENT

**American Family Life Assurance Company of Columbus (AFLAC),** Worldwide Headquarters: Columbus, GA 31999
For information, call toll-free 1-800-99-AFLAC (1-800-992-3522).

Name of Policyholder: _____ SS#: _____

Policy Number (s): _____

Date of Birth: _____ Telephone #: _____ Best time to call: _____

Current Address of Policyholder: _____

City: _____ State: _____ Zip: _____

Name of Employer/Payroll Account: _____

Associate/Agent's Signature: _____ Writing Number: _____
(If applicable) Licensed Resident Associate/Agent

**PLEASE MAKE THE FOLLOWING ADDITION TO MY POLICY:**

❑ **ADDITION**

Person(s) to be added: _____

Date(s) of birth: _____ Relationship: _____

Reason(s) for addition(s): _____

Effective date of addition(s): _____

Type of coverage now desired: ❑ Two-Parent Family ❑ One-Parent Family ❑ Husband-Wife

❑ **REINSTATEMENT**

Attached is $ _____ to cover _____ months premium. I hereby apply for reinstatement of my coverage as indicated above.

**PLEASE READ THE FOLLOWING**

All portions of this form applicable to your type of coverage must be completed before your application can be processed; therefore, please be sure to indicate the name of any person who has a history of the medical conditions listed, if applicable, in the spaces provided. **If none, please write the word "none".**

**PLEASE COMPLETE QUESTIONS 1 AND 2 FOR REINSTATEMENTS OR ADDITIONS TO ALL TYPES OF COVERAGE**

1. Has anyone applying for reinstatement or addition ever been diagnosed with acquired immune deficiency syndrome (AIDS) by a member of the medical profession or tested positive for HIV (human immunodeficiency virus)? ❑ Yes ❑ No
2. Is anyone applying for reinstatement or addition currently disabled? ❑ Yes ❑ No

If yes to question 2 above, please give details below:

Name of Individual: Condition:

**PLEASE COMPLETE THE SECTION THAT APPLIES TO YOU**

☐ **[CANCER]**

3. I represent that to the best of my knowledge, information and belief no person to be reinstated or added to this policy(s) has now or has ever been diagnosed or treated for cancer in any form or been advised by a member of the medical profession to have any diagnostic test related to cancer that has not yet been performed except:

_____, who may be subject to further underwriting to
Last First MI **(If none, write "none")**
determine eligibility for coverage on the policy. Please state condition: _____ and date of last treatment _____ .

Has the person(s) designated above:
(a) received treatment for cancer in the last five years? ☐ Yes ☐ No
(b) received hormonal therapy for cancer within the last 12 months? ☐ Yes ☐ No
If no to (a) and (b), please complete Internal Malignancy Form provided by your associate/agent.
If yes to (a), what type of cancer was it:
☐ Skin cancer or Melanomas of Clark's Level I or II?
☐ Internal cancer or Melanomas of Clark's Level III or higher?
policy.)
If yes to (a) and/or (b), further underwriting may be required to determine eligibility for coverage.

**Please complete question 4 below only if requesting reinstatement of Specified (Dread) Disease Rider.**

4. Has anyone to be covered under this rider ever had adrenal hypofunction (Addison's disease), ALS (amyotrophic lateral sclerosis), cerebral palsy, cystic fibrosis, diphtheria, encephalitis, Huntington's chorea, Legionnaires' disease, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, scleroderma, sickle-cell anemia, systemic lupus, tetanus or tuberculosis in any form?
☐ Yes ☐ No If yes, was it the: ☐ Named Insured ☐ Spouse ☐ Child? If "child," please list the name of the child(ren) _____ . If yes, further underwriting may be required to determine eligibility for coverage.

☐ **[INTENSIVE CARE]**

5. I represent to the best of my knowledge, information and belief, no member of the medical profession has ever treated or diagnosed any person to be reinstated or added to this intensive care policy(s) for a heart attack, angina, heart surgery, or any abnormal condition of the heart except:

_____, who may be subject to further underwriting to
Last First MI **(If none, write "none")**
determine eligibility for coverage on the policy. Please state condition: _____ and date of last occurrence/treatment _____ .

**Please complete question 6 below only if requesting reinstatement of Organ Transplant Rider.**

6. Has a member of the medical profession ever diagnosed or treated anyone to be covered under this rider for kidney disease, congestive heart failure, congenital heart disease or heart attack? ☐ Yes ☐ No
Name of person(s) diagnosed or treated for any of the above, and the condition must be listed in the following space:

_____
NAME CONDITION
If yes, further underwriting may be required to determine eligibility for coverage.

☐ **[ACCIDENT]**

7. I represent to the best of my knowledge, information and belief that no person to be reinstated or added to this accident policy has in the past year been treated or diagnosed by a member of the medical profession for back, neck or joint injury or disorder except:

_____, who may be subject to further underwriting to
Last First MI **(If none, write "none")**
determine eligibility for coverage on the policy. **If your Accident policy includes disability income riders, you must complete the next section.**

❑ **[PERSONAL SHORT TERM DISABILITY/DISABILITY RIDERS --- REINSTATEMENTS ONLY]**

8. During the past 24 months, has anyone applying for reinstatement been advised by a physician to have tests, treatment or surgery that has not yet been done? **If yes, please give details in item 17 below.** ❑ Yes ❑ No
9. Do you work fewer than 30 hours per week in your primary (full-time) occupation? ❑ Yes ❑ No
10. In the past two years, has a member of the medical profession diagnosed you with or treated you for any of the following: chronic bronchitis, asthma, hypertension or back, neck or joint injury or disorder? Please circle condition(s) and provide additional information in item 17 below. ❑ Yes ❑ No
11. Have you received disability benefits or claimed workers' compensation in the last two years? ❑ Yes ❑ No
12. In the past year, have you missed five consecutive days or 10 total days of work due to your sickness or injury? ❑ Yes ❑ No
13. In the past year, have you been confined in a hospital as an inpatient? ❑ Yes ❑ No
14. Is anyone taking any prescription or over-the-counter medication? If yes, please provide details in item 16 below. ❑ Yes ❑ No
15. Have you or anyone to be covered under this policy been charged with driving under the influence of alcohol or narcotics within the last 5 years? ❑ Yes ❑ No

If you answered yes to any of questions 8 thru 13, please provide details about the nature of your occupation, illness, injury, or need for medical attention in item 17 below.

If you answered yes to any of questions 8 thru 15, further underwriting may be required to determine eligibility for coverage.

| 16. **Medication Name** | **Dosage and Frequency** | **Nature of Illness** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

17. Additional Information: _____

❑ **[HOSPITAL INDEMNITY]**

18. Is anyone to be covered currently confined in a hospital or nursing home, or has a physician recommended hospitalization? ❑ Yes ❑ No
19. Has anyone to be covered been confined in a hospital for 14 or more hours within the last 36 months because of any of the following? (Circle all that apply.) Angina, heart surgery, transient ischemic attack (TIA), congestive heart failure, stroke, cerebral vascular insufficiency, heart attack, internal cancer or peripheral vascular disease. ❑ Yes ❑ No
20. Has anyone to be covered been confined in a hospital for 14 or more hours within the last 12 months because of any of the following? (Circle all that apply.) Emphysema, Parkinson's disease, sickle-cell anemia, chronic liver disease, asthma or chronic obstructive pulmonary disease. ❑ Yes ❑ No
21. Has anyone to be covered ever been treated or diagnosed by a member of the medical profession as having any of the following? (Circle all that apply.) Alzheimer's disease, systemic lupus, end-stage renal disease, senile dementia, kidney failure or insulin-dependent diabetes. ❑ Yes ❑ No
22. If any of Questions 18 thru 21 is answered "yes," the name and the relationship of the person(s) must be shown in the following space. If yes, further underwriting may be required to determine eligibility for coverage. _____

## NOTICE OF INFORMATION PRACTICES

To process your request, AFLAC may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by AFLAC may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters.

## AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (defined below) to American Family Life Assurance Company of Columbus (AFLAC) or any person or group acting on their part: any medical professional, any medical care institution, insurer, reinsurer, government agency, consumer reporting agency or employer. "Information" means facts of a medical nature in regard to my physical or mental condition, employment, other insurance coverage, or any other nonmedical facts. I understand that this information will be used by AFLAC to determine eligibility for insurance. I agree that this authorization is valid for 30 months from the date signed. I know that I, or an individual authorized to act on my behalf has a right to receive a copy of this authorization upon request. I agree that a copy of this authorization is as valid as the original.

The undersigned applicant and associate certify that the applicant has read, or had read to him/her, the completed application and that he/she realize that any false statement or misrepresentation there, may result in loss of coverage under the policy.

Applicant's Signature (X): _____ Date: _____

Associate's Signature (if applicable) _____ Date: _____

## Cafeteria/Section 125 Plans

If premiums for your policy are deducted on a pre-tax basis, this section should be completed by your plan administrator.

Account Approval Signature: _____ Date: _____

Printed Name: _____

**MAKE CHECKS PAYABLE TO AFLAC. FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**

### FOR WORLDWIDE HEADQUARTERS USE ONLY

PTD _____ No. Months Dropped _____
Lapsed _____ $ Applied _____
Reinstated _____ No. Months _____
Premiums Applied From _____ New PTD _____
Initials _____